in cases in which such rates are not available, on the average full cost of these items, exclusive of any costs considered for purposes of any outpatient visit. A separate charge shall be made for each item provided.

(7) Charges for aero-medical evacuation will be based on the full cost of the aero-medical evacuation services.

(g) *Special rule for services ordered and paid for by a facility of the Uniformed Services but provided by another provider.* In cases where a facility of the Uniformed Services purchases ancillary services or procedures, from a source other than a Uniformed Services facility, the cost of the purchased services will be added to the standard rate. Examples of ancillary services and other procedures covered by this special rule include (but are not limited to): laboratory, radiology, pharmacy, pulmonary function, cardiac catheterization, hemodialysis, hyperbaric medicine, electrocardiography, electroencephalography, electroneuromyography, pulmonary function, inhalation and respiratory therapy and physical therapy services.

(h) *Special rule for TRICARE Resource Sharing Agreements.* Services provided in facilities of the Uniformed Services in whole or in part through personnel or other resources supplied under a TRICARE Resource Sharing Agreement under 32 CFR 199.17(h) are considered for purposes of this part as services provided by the facility of the Uniformed Services. Thus, third party payers will receive a claim for such services in the same manner and for the same charges as any similar services provided by a facility of the Uniformed Services.

(i) *Alternative determination of reasonable charges.* Any third party payer that can satisfactorily demonstrate a prevailing rate of payment in the same geographic area for the same or similar aggregate groups of services that is less than the charges prescribed under this section may, with the agreement of the facility of the Uniformed Services (or other authorized representatives of the United States), limit payments under 10 U.S.C. 1095 to that prevailing rate for those services. The determination of the third party payer's prevailing rate shall be based on a review of valid contractual arrangements with other facilities or providers constituting a majority of the services for which payment is made under the third party payer's plan. This paragraph does not apply to cases covered by § 220.11.

(j) *Exception authority for extraordinary circumstances.* The Assistant Secretary of Defense (Health Affairs) may authorize exceptions to this section, not inconsistent with law, based on extraordinary circumstances.

[57 FR 41101, Sept. 9, 1992, as amended at 59 FR 49002, Sept. 26, 1994; 61 FR 6542, Feb. 21, 1996; 62 FR 941, Jan. 7, 1997; 65 FR 7728, Feb. 16, 2000; 67 FR 57740, Sept. 12, 2002]

§ 220.9 Rights and obligations of beneficiaries.

(a) *No additional cost share.* Pursuant to 10 U.S.C. 1095(a)(2), uniformed services beneficiaries will not be required to pay to the facility of the uniformed services any amount greater than the normal medical services or subsistence charges (under 10 U.S.C. 1075 or 1078). In every case in which payment from a third party payer is received, it will be considered as satisfying the normal medical services or subsistence charges, and no further payment from the beneficiary will be required.

(b) *Availability of healthcare services unaffected.* The availability of healthcare services in any facility of the Uniformed Services will not be affected by the participation or nonparticipation of a Uniformed Services beneficiary in a health care plan of a third party payer. Whether or not a Uniformed Services beneficiary is covered by a third party payer's plan will not be considered in determining the availability of healthcare services in a facility of the Uniformed Services.

(c) *Obligation to disclose information and cooperate with collection efforts.* (1) Uniformed Services beneficiaries are required to provide correct information to the facility of the Uniformed Services regarding whether the beneficiary is covered by a third party payer's plan. Such beneficiaries are also required to provide correct information regarding whether particular health care services might be covered by a third party payer's plan, including services arising from an accident or workplace injury or illness. In the

event a third party payer's plan might be applicable, a beneficiary has an obligation to provide such information as may be necessary to carry out 10 U.S.C. 1095 and this part, including identification of policy numbers, claim numbers, involved parties and their representatives, and other relevant information.

(2) Uniformed Services beneficiaries are required to take other reasonable steps to cooperate with the efforts of the facility of the Uniformed Services to make collections under 10 U.S.C. 1095 and this part, such as submitting to the third party payer (or other entity involved in adjudicating a claim) any requests or documentation that might be required by the third party payer (or other entity), if consistent with this part, to facilitate payment under this part.

(3) Intentionally providing false information or willfully failing to satisfy a beneficiary's obligations are grounds for disqualification for health care services from facilities of the Uniformed Services.

(d) *Mandatory disclosure of Social Security account numbers.* Pursuant to 10 U.S.C. 1095(k)(2), every covered beneficiary eligible for care in facilities of the Uniformed Services is, as a condition of eligibility, required to disclose to authorized personnel his or her Social Security account number.

[55 FR 21748, May 29, 1990, as amended at 57 FR 41102, Sept. 9, 1992; 63 FR 11600, Mar. 10, 1998; 65 FR 7729, Feb. 16, 2000]

§ 220.10 Special rules for Medicare supplemental plans.

(a) *Statutory obligation of Medicare supplemental plans to pay.* The obligation of a Medicare supplemental plan to pay shall be determined as if the facility of the Uniformed Services were a medicare-eligible provider and the services provided as if they were Medicare-covered services. A Medicare supplemental plan is required to pay only to the extent that the plan would have incurred a payment obligation if the services had been furnished by a Medicare eligible provider.

(b) *Inpatient hospital care charges.* (1) Notwithstanding the provisions of § 220.8, charges to Medicare supplemental plans for inpatient hospital care services provided to beneficiaries of such plans shall not, for any admission, exceed the Medicare inpatient hospital deductible amount.

(2) Only one deductible charge shall be made per hospital admission (or Medicare benefit period), regardless of whether the admission is to a facility of the Uniformed Services or a Medicare certified civilian hospital. To ensure that a Medicare supplemental insurer is not charged the inpatient hospital deductible twice when an individual who is entitled to benefits under both DoD retiree benefits and Medicare, the following payment rules apply:

(i) If a dual beneficiary is first admitted to a Medicare-certified hospital and is later admitted to a facility of the Uniformed Services within the same benefit period initiated by the admission to the Medicare-certified hospital, the facility of the Uniformed Services shall not charge the Medicare supplemental insurance plan an inpatient hospital deductible.

(ii) If a dual beneficiary is admitted first to a facility of the Uniformed Services and secondly to a Medicare-certified hospital within 60 days of discharge from the facility of the Uniformed Services, the facility of the Uniformed Services shall refund to the Medicare supplemental insurer any inpatient hospital deductible that the insurer paid to the facility of the Uniformed Services so that it may pay the deductible to the Medicare-certified hospital.

(c) *Charges for Healthcare services other than inpatient deductible amount.* (1) The Assistant Secretary of Defense (Health Affairs) may establish charge amounts for Medicare supplemental plans to collect reasonable charges for inpatient and outpatient copayments and other services covered by the Medicare supplemental plan. Any such schedule of charge amounts shall:

(i) Be based on percentage amounts of the per diem, per visit and other rates established by § 220.8 comparable to the percentage amounts of beneficiary financial responsibility under Medicare for the service involved;

(ii) Include adjustments, as appropriate, to identify major components of the all inclusive per diem or per visit